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To:
Special Commission on the Health Care Payment System in Massachusetts
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Sarah Iselin Co-chair
Dolores Mitchell
Dr Alice Coombs VP Mass Med Society
and all other members of the commission
Richard Moore MA-Senator; Co-chair committee on health care financing
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REVAMPING HEALTHCARE IN MASSACHUSETTS or THE END OF HEALTHCARE IN MASSACHUSETTS.

This letter comes from the heart. Please read it carefully and take it seriously – it is not biased towards the interests of medical doctors and specialist, even though I am one myself. It is purely meant as an appeal to reconsider the ideas for healthcare reform as they were outlined in the Boston Globe article from May 7, along with some suggestions for more rational and potentially more successful reform. I have followed the recent flurry in the healthcare debate very carefully and have grown increasingly concerned about the direction this is taking.

I am a physician from Germany, living and working now in the USA for a number of years. When I came to the US, I regarded the US-healthcare system as one of the highest in quality with regard to the delivery of care, even though there were the obvious shortcomings with regard to universal insurance etc. The medical education was superb and the team approach to patient care exemplary. Over the last 5 years or so I have witnessed the gradual destruction of this system, and many issues have emerged that compromise the quality of care delivered. I am not going to bore you with all of these – but just to name a few: lack of primary care access and diminishing quality of primary care, overutilization of ER's, liability and litigation in medicine leading to overutilization of testing, availability of newer, more sophisticated (also more expensive) testing, rising prescription costs, and FRAGMENTATION of healthcare (patients attitude towards having a specialist for a lot of their aspects of healthcare, with the PCP losing sight of all facets of their care – the patient frequently bypassing the PCP and going to their specialist for even simple issues that PCP's should take care of).

Patient expectations are very high and rising, regarding having access to PCP and specialists, getting necessary testing done fast, and getting treatment (interventions, medications) expeditiously. THIS is what drives the engine ALONG with the fear of health care providers to miss something and getting sued. Many patients demand specialist care even for issues that should easily be handled by a PCP – and PCP's frequently don't feel comfortable without the back-up of a specialists consultation, so "all bases are covered".

Massachusetts went already on a very costly course to provide health insurance for (nearly) everybody, a very honorable feat, but in my opinion fundamentally flawed because the cost is on the shoulders of the government/taxpayer without any instrument to hold the cost down (see suggestions below for improvement).

You are saying the healthcare spending is growing 8% annually in Massachusetts. I have not seen any of that increase end up in my or my colleagues pocket, nor in the pocket of the community hospital network I am part of. This money is probably ending up with insurances, administrative agencies and health-related companies (e.g. technology firms and pharmaceutical industry, etc.). Reimbursement for many of the services I provide has not increased in years, some has decreased substantially.

You are also saying that the fee-for service system pushed up costs by encouraging doctors and hospitals to do lots of procedures, and do those that are most profitable, even if they're not always necessary. This view is not quite correct: The ordering physician generally does not get paid for ordering procedures, e.g. if I order labwork, a CT scan or an MRI, I don't get anything extra. I actually increase my workload, since I have to follow-up on the test result, communicate it to the patient and PCP and make decisions based on the findings. The second issue is that the ordering of many tests is already regulated heavily (e.g. radiographic imaging like CT's and MRI's). Many of these new tests have revolutionized medical diagnosis, but are admittedly expensive. Frequent utilization is causing a problem, but patient expectation and liability concerns are the main engine driving this. Insurances are also monitoring which health care providers are ordering which tests how often and how "efficiently". They use this data to measure "quality" and efficiency of health care delivery and compare physicians (problematic in their methodology as the current lawsuit against the GIC shows, **but if it were done correctly, we would be all for it).**

Ordering less tests – to stay within a "global" budget - will potentially result in a delay in diagnosis, patient dissatisfaction, decreased quality of care and ultimately increased follow-up costs. The proposed system would impose severe limitations on the availability of diagnostic and therapeutic techniques for today's increasingly sick population. What is needed is continued regulation about what tests can be ordered when, but in a more effective and "fair" manner so quality of care does not suffer.

To that regard a couple of other remarks:

- You have to consider that the quoted cost increase is in part related to increasing morbidity in the population (e.g. increase in the elderly population), and the (unfortunate but unavoidable) cost of newer diagnostic and therapeutic tools that medical progress has produced. The cost increase does not reflect increasing profits to doctors and hospitals. In my specialty, the reimbursement for many of my services (office visits/consultations and procedures) has not increased in years, and I hear from many of my colleagues in other fields of medicine similar assessments.

- Health Care providers work very hard and take on a lot of responsibility. Just like in any other job, you have to create incentives for performance. How are you going to motivate a young medical student to go into a career in primary care, or in various specialties? The only reliable way is to create incentives, professionally and financially. No internist or general surgeon will undergo a rigorous subspecialty training program (with several more years of very low pay and exhaustive workload) unless there is a rewarding career in many respects awaiting at the end. Massachusetts has already a problem attracting physicians (we are <u>not</u> <u>even</u> talking the best physicians – like it used to be). Cost of living, taxes and malpractice is higher than most places, and Medicare reimbursement is lower than most places. If you start a capitated system with so-called "global" payments, the number of physicians/health care providers coming to Massachusetts to practice will drop for sure. Even worse, whoever of the practicing workforce can do so, will want to leave.

- One of the major issues we grapple with on a daily basis is the inadequate use of ER's. Not only does the ER see a lot of patients sent there by their PCP's for work-up of an acute issue that could – with better resources and incentives – be worked up just as good through the PCP office - much cheaper! The ER's also see a lot of patients that don't even bother going to the PCP first– for headaches, abdominal pain, back pain etc… This creates enormous cost because the ER physician who does not have a relationship with the patient has to do a complete work-up every time to be sure nothing is missed. A PCP who knows the patient from prior visits could judge much better what is appropriate and reasonable to evaluate the symptoms.

- Primary Care providers currently get reimbursed quite well for healthy patient evaluations (i.e. yearly physicals) which they can do very quick and efficiently. Visits of patients with active problems require more time and effort on behalf of the PCP, with f/u on tests ordered etc. Ordering tests also "hurts" their statistics with the insurances and network regulatory systems (e.g. PHO's). Therefore there is little incentive for the PCP to start working up patients – leading to the relatively low threshold of sending them to specialists or to the ER. In order to lower this costly approach <u>you have to incentivize PCP's to "take care" of</u>

patients, start solving their problems, rather than sending them other places that generate more cost for the system.

- This is directly related to the access problems that patients face: with regard to access to PCP's, they rather book "healthy patient evaluations' and have little time in urgent care slots to provide comprehensive care for active problems. The next step is for PCP's to refer to specialists, who in turn get bogged down with requests for consultations about problems that in the past would never have required a specialist consultation. Or – if the patient complains repeated to the PCP about the same symptoms, a referral to the ER is frequently made to provide a good portion of the work-up in one sitting. I see this every day – and I can tell you there is a lot of money to be saved by changing this pattern of behavior by us doctors. As a specialist, I rather concentrate on the referrals that really need my specialist expertise. My schedule would be much easier to manage than with the current expectations for access demonstrated by PCP's and patients.

- How would "global payments" be allocated if a patient switches PCP's? The "old" PCP may have done a lot of testing to figure out a patient's symptoms; the patient is not satisfied with the answers provided and seeks care with a new PCP, and spends the rest of the year under his/her care – this new PCP may actually be taking care of the patient for most of the remaining year, if the testing by the first PCP and the switch took place early in the year. It does not seem fair then, that the second PCP would be reimbursed equally or even more by the proposed system. You may argue that he is putting more time in for the patient the rest of the year, but all the diagnostic thinking and work (involving ordering and interpreting appropriate testing) was crucial in providing answers - all done by the "old" PCP. This is just one of many potential problems with a "global payment" system. How will allocation of the "global payment" work, if the PCP merely refers the patient to the specialist, who then orders the appropriate tests? Out of whose "budget' will these costs be taken?

- The fee-for service system can work, if the **appropriate** quality and efficiency measures are put into place. Global payments will only create an incentive to limit services to patients, many of which may be medically necessary. You are stating that higher payments could be provided for very sick patients or those at risk of needing high cost treatments. Who is going to make these decisions? Hopefully not any of the agencies that are currently deciding whether an MRI or CT is indicated for some of our patients. Their expertise is lacking, and the criteria used for determination very impractical. Who is going to monitor the quality of care delivered by the health care provider and how. The tools so far presented by insurers (e.g. GIC tiering system) are very inadequate and not suitable to monitor this. How much is the monitoring going to cost?

THE PROPOSED "GLOBAL" PAYMENT SYSTEM IS NOT A SOLUTION. It will probably lower the money spent on healthcare **in the short run**, but it will bring an even bigger problem of access to specialist care, modern testing, and compromise quality of

care. Capitation has failed before and no modification is going to prevent dire consequences: decreased access of patients to needed specialist care, delays in diagnosis and treatment, decreased patient satisfaction, unhappy healthcare providers that work very hard, and get no incentive for their work, except for "more money" the more care they withhold. WRONG STRATEGY.

I agree with the urgency, with the push for electronic medical records to avoid duplication of tests, and for a complete reform of the health care system. However, just like I disagree with the method Massachusetts uses to provide insurance to everyone, I disagree with the plan the Special Commission on the Health Care Payment System is presenting. The expected coordination of care would not necessarily improve quality of care – as suggested in the article. It more likely will result in delivery of very bare-bones care that would not meet the current need of our aging population. Furthermore, it could mean the end for many small hospital systems and physician's practices that don't have the necessary logistics and means to survive in such an environment. Large organizations like Partners Healthcare may be able to function, but it would be detrimental to healthcare if such a monopoly would expand even further than it already has.

This cannot go on like this – the system is about to break down.
THE ONLY WAY OUT OF THIS SPIRAL IS TO CHANGE AT LEAST FOUR THINGS:

1) medical malpractice reform
2) create behavioral change in the health care consumer, by creating incentives
3) measure quality and efficiency of care very differently.
4) create incentives for PCP's to provide care to patients with active medical problems (rather than sending them to ER's or specialists)

Furthermore, the change has to occur nationwide, not just in one state. To me it is just ridiculous that this country has a very standardized medical education as a whole, but every state has their own rules regarding health care delivery. It is a huge headache for a patient from another state to get treated outside of his state, and a headache for the doctors as well, to get reimbursement from the patient's insurance for services rendered. All that, with physicians who have taken the same federal board examination, but have to apply for a state license in every state they practice. WHY? This system already eats up a lot of resources and money, and for what! In Germany – also a federal republic with a standardized medical education – licensing after passing the boards is reciprocal for all the states within Germany, and insurance is nationwide and portable, something that does not exist here. God forbid you get sick abroad as an American – the ramifications for many insured and uninsured are so complicated.

The issues at hand – and my suggestions for improvement/reform are:

1) Universal coverage – preferably nationwide insurance plans that are also portable (meaning: someone loses their job; the person keeps their insurance and the government subsidizes/pays those premiums. If changing jobs, the insurance stays

the same). Generally I would advocate that private insurers provide the insurance product, (not the government) so there is competition in the market to provide a good product as cheap as possible. Premiums are paid 50% by the employer, 50 % by the employee (takes the burden off the government/taxpayer and creates an incentive for the employee to budget healthcare), with built-in incentives from the insurer and employer to reward healthy behavior (Safeway created such a program in the past and saved a lot of money for health care). All employers should be required to offer health insurance, no matter what size their company is.

2) The insurance product has to fulfill certain government mandated minimum standards: e.g. preventive medicine covered to 100%, PCP visits covered to 100% (copay? to discourage overutilization), specialist visits with a copay, routine imaging and routine labs fully covered. Advanced imaging – except in emergencies – requires review, as presently done, with improved criteria to be met for approval. Surgery and Inpatient care covered with details to be determined. Good prescription drug coverage is important since we see often that patients that cannot afford the medications will not take them/buy them and bounce back into the hospital or present with worsening symptoms, thus creating more cost to the system, than if they had coverage for the prescription's cost in the first place. Obviously the pharmaceutical industry would have to make drastic concessions regarding pricing – drug prices are so much higher here than in other countries which has always been unexplainable to me.

3) ER visits need to be regulated much better. Mandatory PCP visits for a minimum work-up would be one way to regulate that, except, of course, for defined emergencies. The reimbursement to PCP's for acute care visits (active medical problems) needs to be such that it is attractive for a PCP to spend time with such patients. Capitation is going to have the opposite effect!

4) Insurances cannot reject applicants for preexisting conditions. The regular health insurances in Germany, e.g. were not allowed to do that and had to accommodate all applicants that chose their product (and hope that the mix of members would provide them a profit, forcing them to design insurance products that attract all groups of society, not just healthy ones)

5) If you want to be really revolutionary, you may want to think about dismantling the VA system, which is a prime example of uncoordinated healthcare delivery. Veterans are service connected for some conditions but not for others, so they get some of their care there, and other care elsewhere – very confusing. Instead; one could create a system, where a Veteran could qualify for a certain percentage of his healthcare insurance premium depending on his level of "service-connection".

6) Medicare and Medicaid could also be dismantled, creating instead an agency that subsidizes/pays for the insurance of unemployed and poor, rather than sponsoring separate Medicare/Medicaid health plans with their own rules and reimbursement systems (requiring huge bodies of personnel for billing, reimbursement, claim

processing etc – all that could be saved). Seniors may have to pay a percentage of their health insurance themselves (maybe insurances have to offer the mandatory plan coverage to seniors at a discount, so it stays affordable for the elderly). I would guess that the insurances providing the mandatory insurance plan system will have many more members in their plans from which they collect premiums compared to now; therefore the overall income for the insurers will probably be fairly high, providing the money needed for coverage (although probably at less of a profit than the insurance companies currently enjoy).

7) Legal reform / tort reform is going to be **absolutely necessary** to prevent the overutilization of tests that currently exists, driven by the need" to cover my butt". Standards of care are well defined and it should be possible to create a system where true medical errors continue to be prosecutable, whereas the many lawsuits borne out of false expectations could be avoided. Decreased fear of litigation will also results in less referrals to specialists and ER. One of the least talked about motors for malpractice lawsuits is the fact that they are lucrative for malpractice attorneys. If attorneys would be reimbursed by the hour (of work) for these cases, and not by a percentage of the award, the number of lawsuits would probably be more reflective of the true need. Germany (again my example) has a decent legal system providing everybody access to lawyers for such claims. Lawyers generally make a very decent living in Germany. However, the numbers of medical malpractice lawsuits are much lower than here and the awards given to the affected patient much more realistic than here. Malpractice insurance cost would go down, and the defensive medicine all of us **have to** practice here could become a thing of the past, again lowering the cost of healthcare.

8) Creation of a web-based secure health record for each patient. This would eliminate duplication of tests, since results of previous tests are immediately available for review by the treating physician. I often find myself not having all results of previous tests available to me when I see a patient referred to me, even though my secretary tries to get old records before the visit. So, when I order lab work, there is often some duplication – and this can add up to a large amount of money nationwide. Teaching hospitals/tertiary care centers frequently repeat some of the tests done in community hospitals – the reason for that is frequently very doubtful. Web-based health records could eliminate the need for much of this waste.

9) Reform of the reimbursement system certainly needs to be done. It should stay fee – for-service, but with certain limitations that prohibit overzealous billing – kind of a hybrid between DRG's and fee-for service. For example, routine colonoscopy screening could have a certain fee attached to it (e.g. tiered by the level of complexity, polyp removal etc.) , whereas workup for "uncomplicated acid reflux" – since fairly standardized – is paid as a flat fee, and the physician has to determine what tests are reasonable in the individual situation - with quality measures in place to assure good care (just an example). To stick with that example, "complicated reflux" (e.g with trouble swallowing, erosions/ulcerations,

Barrett's esophagus or anemia etc) would be placed in a different "DRG" since more advanced testing and treatments would be medically necessary. I think a system like that would provide incentive enough for health care providers to use tests wisely and economically, but would not limit the availability of more advanced medical care to the patient who needs this for a specific symptom or diagnosis, therefore allowing the physician to deliver state of the art medicine. Neither the patient nor the health care provider should be put in a position where necessary health care cannot be delivered because of budget considerations / global payments. That is a recipe for disaster.

Rather than "castrating" the system where it hurts the patient the most (i.e. at the level of the direct provider of health care, who had to adjust to outside forces like litigation and patient expectations), the system itself needs to be changed where it is fundamentally flawed: at the level of the insurances, legal framework, and communication. Drastic changes can create a framework – mandated by smart laws – for affordable insurance for everyone, providing access to the existing network of physicians, without limiting the physician's spectrum of tools to treat today's medical problems that face an ever increasing number of citizens.

Respectfully

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